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Department of Health Care Policy & Financing

Network Adequacy Quarterly Report Template

Managed Care Entity: *Northeast Health Partners*

Line of Business: *RAE*

Contract Number: *19-107508*

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Report Submitted by: *Alma Mejorado*

Report Submitted on: *April 30, 2021*

Report due by *04/30/2021*, covering the MCE's network from *01/01/2021 – 03/31/2021*, FY*21* Q*3*

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Instructions for Using the Network Adequacy Quarterly Report Template

This document contains the March 2021 release of a standardized template for use by all Colorado Medicaid or CHP+ Managed Care Entities (MCEs) for quarterly Network Adequacy (NA) reporting to the Colorado Department of Health Care Policy and Financing (HCPF). Each MCE should generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. Network categories required for quarterly reporting are defined in the CO Network Adequacy Crosswalk Definitions (March 2021 version).

The practitioners, practice sites, and entities included in the quarterly NA report will include ordering, referring, and servicing contractors that provide care through a Colorado Medicaid or CHP+ MCE. To ensure consistent data collection across MCEs, each MCE must use this HCPF-approved report template (MS Word and MS Excel templates) to present the MCE's quarterly NA report and data for the corresponding practitioners, practice sites, and entities. Report due dates will align with those outlined in the MCE's contract, unless otherwise stated.

Fiscal Year Quarter Reported	Quarterly Reporting Deadline for HCPF	Reporting Date for Member and Network Files
FY 2020-21 Q3	April 2021	March 31, 2021
FY 2020-21 Q4	July 2021	June 30, 2021
FY 2021-22 Q1	October 2021	September 30, 2021
FY 2021-22 Q2	January 2022	December 31, 2021

Definitions

- "MS Word template" refers to the *CO Network Adequacy_Quarterly Report Word Template_F1_0321* document.
- "MS Word MCE Data Requirements" refers to the *CO Network Adequacy_MCE_DataRequirements_F1_0321* document that contains instructions for each MCE's quarterly submission of member and network data.
- "MS Excel Geoaccess Compliance template" refers to the *CO<20##-##>_NAV_FY <####> Q<#> QuarterlyReport_GeoaccessCompliance_<MCE Type>_<MCE Name>* spreadsheet.
  - MCEs will use this file to supply county-level results from their geoaccess compliance calculations, including practitioner to member ratios and time/distance calculations.
- Use the Colorado county designations from the Colorado Rural Health Center to define a county as urban, rural, or frontier; the most recent county-level map is available at the following website:
  - https://coruralhealth.org/resources/maps-resource

  - Note: Urban counties with rural areas (e.g., Larimer County) should be reported with the rural counties and use rural time/distance standards.
- A "practice site" or "practice" refers to a physical healthcare facility at which the healthcare service is performed.
- A "practitioner" refers to an individual that personally performs the healthcare service, excluding single case agreement (SCA) practitioners.
- An "entity" refers to a facility-level healthcare service location (e.g., hospital, pharmacy, imaging service facility, and/or laboratory).

Report Instructions

Each MCE should use this template to generate one quarterly NA report for each applicable line of business (i.e., CHP+ MCO, Medicaid MCO, and RAE); the report shall contain template elements applicable to the line of business. The MCE should update the highlighted, italicized data fields on the cover page of this template to reflect their contact information, contract information, and report dates associated with the current report submission.

This report template contains a comprehensive list of NA requirements for the CHP+ MCO, Medicaid MCO, and RAE lines of business. Each table in this MS Word document contains a header row which confirms the applicable line(s) of business for each response. The table below shows expected network categories by MCE type. The accompanying MS Excel spreadsheets contain tabs in which network data can be imported (e.g., member counts, ratio results, time/distance calculation results).

Network Category	CHP+ MCO	Medicaid MCO	RAE
Facilities (Entities) (*Hospitals, Pharmacies, Imaging Services, Laboratories*)	X	X	
Prenatal Care and Women's Health Services	X	X	X
Primary Care Providers (PCPs)	X	X	X
Physical Health Specialists	X	X	
Behavioral Health Specialists *(RAEs' network categories include Substance Use Disorder [SUD] treatment coverage that went into effect on 1/1/2021)*	X		X
Ancillary Physical Health Services (*Audiology, Optometry, Podiatry, Occupational/Physical/Speech Therapy*)	X	X	

Questions

- Contact the MCE's Department contract manager or specialist for data submission instructions and assistance with questions or access to HCPF's FTP site.

Establishing and Maintaining the MCE Network

Supporting contract reference: The MCE shall maintain a network that is sufficient in numbers and types of practitioners/practice sites to assure that all covered services to members will be accessible without unreasonable delay. The MCE shall demonstrate that it has the capacity to serve the expected enrollment in that service area.

- To count members, include each unique member enrolled with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 30, 2021).
- To count practitioners/practice sites:
  - Include each unique practitioner/practice sites contracted with the MCE and line of business as of the last day of the measurement period (e.g., March 31, 2021, for the quarterly report due to the Department on April 30, 2021).
  - Define unique individual practitioners using Medicaid ID; a practitioner serving multiple locations should only be counted once for the count of practitioners and ratio calculations.

Define unique practice sites by de-duplicating records by location, such that a single record is shown for each physical location without regard to the number of individual practitioners at the location.

Table 1A-Establishing and Maintaining the MCE Network: Primary Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	91,703	N/A	94,129	N/A
Total primary care practitioners (i.e., PROVCAT codes beginning with "PV" or "PG")	367	N/A	367	N/A
Primary care practitioners accepting new members	340	92.6%	340	92.6%
Primary care practitioners offering after-hours appointments	110	30.0%	110	30.0%
New primary care practitioners contracted during the quarter	51	13.9%	0	0.0%
Primary care practitioners that closed or left the MCE's network during the quarter	1	0.03%	0	0.0%

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Table 1B-Establishing and Maintaining the MCE Network: Primary Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO, RAE
Northeast Health Partners (NHP) maintained a network of sufficient providers across the region in number and type of primary care practitioners to assure that all covered services are accessible to members immediately. NHP contracted with known willing and eligible PCPs within the region. In the areas that NHP met less than one hundred percent (100%) access it was due to the following: ➢ Weld County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30 minute radius. ➢ Lack of practitioners within the time/distance standard by practice level within rural and frontier counties to recruit for contracting, specifically those with specialties such as Primary Care Providers that offer Gynecology services. Obstetricians and Gynecologists in NHPs' counties generally do not perform primary care services including those that are part of contracted organizations such as Banner Health and Catholic Charities (Centura). Therefore, the primary care network does not reflect these practitioners. NHP conducted a review of the Enrollment Summary Report with data of non-contracted providers and the Department of Regulatory Agency (DORA) Registry to identify PCP practices in the region. No additional providers were identified who met the PCP criteria for recruitment within the region. NHP searched for Adult Primary Care and Gynecology practitioners who serve as PCPs across all types of counties within Region 2 (i.e., urban, rural and frontier); however, the search did not yield practitioners for recruitment across the rural and frontier areas of the region. NHP is working with Colorado Plains to add one of their existing family practice locations in Morgan county into the network starting May 2021. NHP is connecting with the new owners of the practices terminated last fiscal year due retirement (Dr. Green) or unforeseen circumstances (Dr. Hoppe). Conversations are focused on education about the ACC program and benefits for their practice to join the NHP network. NHP will document the progress of these conversations in future quarterly reports.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of primary care practitioners to assure that all covered services will be accessible to members without unreasonable delay. If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.
CHP+ MCO, Medicaid MCO, RAE
NHP worked with PCPs to identify the use of telehealth services within the region. The utilization of telehealth did not change from the previous quarterly report. NHP is conducting practice assessments with practices that includes a survey of the practice's use of telehealth service. NHP will document updates in future quarterly reports. Currently, NHP has thirty-five (35) PCP providers who offer telehealth services. Of those practices, we did identify an increase in the number of their rendering providers reporting using telehealth from 35 providers in the first quarter to 92 in the third quarter, a 163% increase. NHP is conducting practice assessments with practices that includes a survey of the practice's use of telehealth service. We are working to resurvey the providers to understand their how they use (if at all) telehealth services and identify challenges for its utilization. Identifying these challenges will help NHP better support PCP practices that are interested in leveraging the service to create access to care. NHP continues to observe overall reduced billing of routine and well-care services during the COVID-19 crisis. Because of the pandemic's impact on its staffing structure, Planned Parenthood's Greeley location offered only some services via telehealth; however, they have reopened the Greeley location to offer full services via face-to-face visits in late February 2021 and continue to offer telehealth services as an option.

Table 2A-Establishing and Maintaining the MCE Network: Behavioral Health Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO, RAE				
Total members	91,703	N/A	94,129	N/A
Total behavioral health practitioners (i.e., PROVCAT codes beginning with "BV" or "BG")	1,918	N/A	1,924	N/A
Behavioral health practitioners accepting new members	1,918	100%	1,895	98.5%
Behavioral health practitioners offering after-hours appointments	496	25.9%	570	29.6%
New behavioral health practitioners contracted during the quarter	96	5.0%	127	6.6%
Behavioral health practitioners that closed or left the MCE's network during the quarter	51	2.6%	121	6.2%

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Table 2B-Establishing and Maintaining the MCE Network: Substance Use Disorder (SUD) Treatment Facilities

Requirement	Previous Quarter	Current Quarter
	Number	Number
Sample	*0*	*0*
RAE		
Total SUD treatment facilities offering American Society of Addiction Medicine (ASAM) Level 3.1 services	N/A	6
Total beds in SUD treatment facilities offering ASAM Level 3.1 services	N/A	70
Total SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total beds in SUD treatment facilities offering ASAM Level 3.3 services	N/A	0
Total SUD treatment facilities offering ASAM Level 3.5 services	N/A	7
Total beds in SUD treatment facilities offering ASAM Level 3.5 services	N/A	202
Total SUD treatment facilities offering ASAM Level 3.7 services	N/A	6
Total beds in SUD treatment facilities offering ASAM Level 3.7 services	N/A	84
Total SUD treatment facilities offering ASAM Level 3.2 WM (Withdrawal Management)	N/A	10
Total beds in SUD treatment facilities offering ASAM Level 3.2 WM services	N/A	178
Total SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	3
Total beds in SUD treatment facilities offering ASAM Level 3.7 WM services	N/A	60

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Table 2C-Establishing and Maintaining the MCE Network: Behavioral Health Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
NHP is primarily a rural and frontier region with one (1) urban county, three (3) rural counties, and six (6) frontier counties. The availability of behavioral health providers in frontier and rural areas with capacity to serve all members is limited, specifically providers who offer specialized training and expertise across all ages, levels of abilities, gender identities, and cultural identities. NHP maintained a network of providers across the region in number and type of behavioral health practitioners to assure that all covered services are accessible to members. NHP primarily has rural and frontier regions, with limited practitioners to meet one hundred percent (100%) time and distance standards for all provider levels. Although NHP has a strong network of practitioners, particularly within the geographic area of Region 2, NHP met less than one hundred percent (100%) access in some areas for the following reasons: ➢ **Weld County, although it has an urban designation, has territories that are more rural where a practitioner is not within 30 miles/30 minute radius**. NHPs' network of behavioral health providers in Weld County met ninety-nine percent (99%) of standards. Since the majority of the practitioners are in the city of Greeley and on the border of Larimer County, Medicaid members residing on the northeast border of the Weld County (which would be described better as a rural community rather than urban) have limited practitioners within a thirty (30) mile radius. In those areas, there are not a sufficient number of behavioral health providers to meet the requirement. Access in these areas have not been impacted by the addition of practitioners in the county as they are not within a thirty (30) mile radius of where these members reside. ➢ **Appropriate time/distance standards for members in counties outside the region, especially frontier counties.** It is challenging to recruit and retain practitioners when they expect a small number, if any, referrals of Medicaid members assigned to NHP. Should members in these counties need additional provider options beyond the network, NHP considers Single Case Agreements (SCAs) when appropriate; however, the use of SCAs for NHP members for out of the region providers has been limited which suggests NHP is meeting the needs of its members through its contracted network.

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Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
➢ **Lack of overall Psychiatric Residential Treatment Facilities and Psychiatric Hospitals and Psychiatric Units in Acute Care Facilities.** Colorado has limited facilities to meet the time/distance standards for a large part of the NHP region, especially in frontier and rural counties. Further, a significant number of contracted facilities that offer critical residential and inpatient services to the NHP membership, are not represented appropriately in the quarterly reports. The manner in which facilities are categorized into a behavioral health provider type affects the overall representation of access to care in the network. Another impact is the temporary closure of Tennyson Center for Children's youth residential center which limits overall access to these services. The facility and its individual practitioners were closed to new members as of this quarterly report. Future reports will document any changes to this facility's status. ➢ **Contracted facilities are included in the report, but are not part of the GeoAccess Compliance report.** NHP has contracts with hospitals and facilities that do not crosswalk to a behavioral health criteria. As part of the *CO Network Adequacy_Network Crosswalk Definitions_0321,* the Psychiatric Residential Treatment Facilities (PRTFs, PROVCAT BF142) criteria changed to require that facilities are to have specific *interChange* provider types and specialty codes. As a result, the number of PRTFs reduced from 76 distinct locations on the last quarterly report to only two (2) locations in this quarterly report. Further, at least six (6) locations that mapped to PRTFs in previous quarterly reports no longer map to any behavioral health criteria. Finally, there are hospitals and facilities with taxonomies that met the criteria of PF150 (Hospital) which is not an allowed Network Category for a RAE. Review of the NPI did not yield additional taxonomies that would crosswalk to behavioral health criteria. The inability to crosswalk these facilities to a behavioral health criterion affects the accurate assessment of geographic access to care in the network. ➢ **Lack of incentive for prescribers to contract.** NHP continues to be concerned about the requirement to have a network of prescribers after the billing changes in the Uniform Service Coding Standards Manual for Evaluation & Management (E&M) Codes. Since prescribers who do not meet the Behavioral Health Specialty Provider Criteria are required to bill Fee-For-Service for Evaluation & Management (E&M) Codes, they no longer have an incentive to contract with NHP.

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Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, NHP focused efforts in recruiting, contracting, and credentialing providers for the SUD benefit expansion that came into effect on January 1, 2021. NHP developed a statewide network of nineteen (19) contracted providers with fifty-seven (57) service locations across all licensure levels with the exception of residential substance use disorder treatment delivered to those suffering from cognitive impairments (ASAM level 3.3) due to no available licensed facilities. Of the contracted providers, eleven (11) providers completed their credentialing by the end of the reporting period (i.e., March 31, 2021) and was included in the files *Network_FAC* and *GeoAccess Compliance*. Staff are supporting these facilities with the completion of their Medicaid enrollment and credentialing applications to join the network. An additional four (4) providers are in contract negotiations. NHP is continuing to monitor utilization and network access to determine recruitment of additional SUD providers into the network. In an effort to ensure access to services and reduce administrative burden, providers who sign a contract and are undergoing the credentialing process have an abridge process for Single Case Agreements (SCAs). Providers negotiating their contracts may also request SCAs to serve new or on-going members until contract negotiations are complete. Based on the file *GeoAccess Compliance*, NHP did not meet time and distance standards across the urban, rural and frontier counties in the region for the new SUD benefit. This issue persists if we account for the contracted facilities pending credentialing. There is an overall lack of sufficient SUD treatment facilities across all ASAM levels within the region, which affects the ability to meet the standard and there are only three (3) SUD treatment facilities located within the region. This included North Range Behavioral Health (NRBH) that offers the continuum of SUD services located in Weld County, Behavioral Treatment Services with one (1) contracted location in Weld County, and Advantage Treatment Center located in Logan County and is in the contracting process. NHP recognizes that access to SUD services within the region isfurther challenged by ongoing statewide workforce shortages, which will require partnership with other RAEs, HCPF and OBH to address. NHP is seeking ways to increase the availability of services for members, including incentivizing providers to offer continuum of services within the region through rate negotiations. NHP will also leverage telehealth services to expand access for services where this modality may be an appropriate such as outpatient SUD services, Intensive Outpatient Program (IOP) and Medication Assisted Treatment (MAT) for the therapy component of their care.

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
NHP continued the following strategies to fill the gaps for overall behavioral health services (both mental health and SUD) within the region: 1- **Tracked utilization, Single Case Agreement (SCA) data, and historical claims information to identify providers who are currently providing services to Health First Colorado (Medicaid) members.** As part of the on-going monitoring of the SCA data, NHP outreached providers that have received multiple SCAs in the previous six (6) months. During the reporting quarter, about a tenth of a percent (0.1%) of NHP members received services through an SCA. NHP focused outreach to initiate credentialing with providers that are part of contracted groups such as Lifestance (formerly Heart Centered Counseling), and KidStuff Child and Family Counseling. These are large contracted groups with high levels of provider staff changes. Due to their location relative to NHP membership, these large groups receive a high volume of member referrals that are served through their new providers as they are onboarded. While their new providers complete credentialing, the groups use SCAs for these providers to start working with NHP members. As a result, their providers have a large number of members under SCA in this quarterly report for whom NHP is working to transition through credentialing and into the network. 2- **Successfully credentialed behavioral health providers by monitoring operational processes.** Although NHP focused on credentialing facilities for the new SUD benefit, staff continued to support providers through education on the application process and outreach to ensure accurate documentation. At the end of the reporting period, five (5) behavioral health providers part of contracted groups located in Weld and Larimer counties joined the network. Further, staff is working with Melissa Memorial Hospital located in Phillips County to contract and credential for outpatient behavioral health services that will help improve access for members in the region.

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Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of behavioral health practitioners to assure that all covered services will be accessible to members without unreasonable delay. If your network includes out-of-state practitioners serving members enrolled with the MCE please describe. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.** **For RAEs, describe any barriers to incorporating the ASAM levels of care for the SUD treatment practitioners, practice sites, and entities. Describe the methods used to monitor the available SUD treatment bed at each ASAM level.**
CHP+ MCO, Medicaid MCO, RAE
3- **Expanded utilization of telehealth services throughout the region for specialty services and members located in our rural and frontier areas.** NHP has seen an increase in the adoption of telehealth services for behavioral health care. During the reporting period, 59 providers reported to offer telehealth services. This is a 195% increase of behavioral health providers offering the services from the 20 providers reported in the first quarter report. The majority of providers that are rendering care through telehealth are utilizing it as an additional option for members, especially larger groups or facilities. Some solo providers have shifted to rendering most services via telehealth as it affords more flexibility and lower overhead costs. NHP retained the expanded use of telehealth services, which has allowed providers to continue to build capacity for a sustainable telehealth service program. NHP continues to educate providers about the benefit as well as updating their information in the system. Furthermore, NHP continues to monitor the changing environment of telehealth to identify additional ways to support providers in expanding these services and monitoring compliance.

Table 3A-Establishing and Maintaining the MCE Network: Specialty Care Data

Requirement	Previous Quarter		Current Quarter	
	Number	Percent	Number	Percent
Sample	*0*	*0.0%*	*0*	*0.0%*
CHP+ MCO, Medicaid MCO				
Total members	N/A	N/A	N/A	N/A
Total specialty care practitioners (i.e., PROVCAT codes beginning with "SV" or "SG")	N/A	N/A	N/A	N/A
Specialty care practitioners accepting new members	N/A	N/A	N/A	N/A
Specialty care practitioners offering after-hours appointments	N/A	N/A	N/A	N/A
New specialty care practitioners contracted during the quarter	N/A	N/A	N/A	N/A
Specialty care practitioners that closed or left the MCE's network during the quarter	N/A	N/A	N/A	N/A

Table 3B-Establishing and Maintaining the MCE Network: Specialty Care Discussion

Describe any barriers that affect the MCE's ability to maintain a sufficient network in number and type of specialty care practitioners to assure that all covered services will be accessible to members without unreasonable delay. **If utilized, describe the impact telehealth services had in overcoming these barriers. Describe the methods used to monitoring the availability and usage of telehealth services.**
CHP+ MCO, Medicaid MCO
N/A

Network Changes

Supporting contract reference: The MCE shall report in writing to the Department, all changes in MCE Networks related to quality of care, competence, or professional conduct.

Table 4-Network Changes: Discussion

If the MCE experienced a positive or negative change in its network related to quality of care, competence, or professional conduct, describe the change and state whether the MCE notified the Department, in writing, within ten (10) business days of the change. **Note: If the MCE experienced a deficiency in the quarter prior to the measurement period, the MCE's response should include a description of the actions taken by the MCE to address the deficiency.**
CHP+ MCO, Medicaid MCO, RAE
During the reporting period, NHP did not experience a change in its network related to quality of care, competence, or professional conduct.

Table 5-CHP+ MCO Network Volume Changes and Notification: Discussion

If the MCE experienced at least a five percent (5%) increase or decrease in its network in a thirty (30) calendar day period, describe the change and answer the following questions: **Did the MCE notify the Department, in writing, within ten (10) business days of the change?** **Was the change due to a practitioner/practice site/entity's request to withdraw; was the change due to the MCE's activities to obtain or retain NCQA accreditation?** **Was the change due to a practitioner/practice site/entity's failure to receive credentialing or re-credentialing from the MCE?**
CHP+ MCO
N/A

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Inadequate Network Policies

Supporting contract reference: If the MCE fails to maintain an adequate network that provides members with access to PCPs within a county in the MCE's Service Area, the Department may designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members by providing the MCE a thirty (30) calendar day written notice.

Table 6-CHP+ MCO Inadequate Access to PCPs: Discussion

Did the MCE fail to maintain an adequate network that provides members with access to PCPs within a county in the MCE's service area? If the MCE answered "yes", did the Department designate that county as a mixed county for the purpose of offering the option of an HMO or the State's self-funded network to eligible members?
CHP+ MCO
N/A

Table 7-CHP+ MCO Discontinue Services to an Entire County: Discussion

Did the MCE discontinue providing covered services to members within an entire county within the MCE's service area? If the MCE answered "yes", did the MCE provide no less than sixty (60) calendar days prior written notice to the Department of the MCE's intent to discontinue such services?
CHP+ MCO
N/A

Table 8-CHP+ MCO Provider Network Changes: Discussion

Did the MCE experience an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability or capacity within the provider network? If the MCE answered "yes", did the MCE notify the Department, in writing, of the change?
CHP+ MCO
N/A

Appointment Timeliness Standards

Supporting contract reference: The MCE shall provide coverage of emergency and non-urgent medical services. The MCE shall have written policies and procedures describing how members can receive coverage of emergency services or urgently needed services while temporarily absent from the MCE's service area.

Table 9-Physical Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to physical health services. Describe findings specific to the current reporting period.
CHP+ MCO, Medicaid MCO, RAE
Primary care providers are required to maintain established office/service hours and access to appointments for new and established Medicaid members within seven (7) days of request, and urgent access shall be available within twenty-four (24) hours from the initial identification of need. Audits conducted between January 2021 through March 2021 across 23 primary care provider practices assessed appointment availability for new Medicaid members, existing Medicaid members, and whether same day appointments were offered. Results from the audits were as follows: • Seventy-eight percent (78%) reported availability within standards for a new Medicaid member. • Eighty-three percent (83%) reported availability within standards for an established Medicaid member. • Ninety-six percent (96%) offered same day appointments. • Eighty-three percent (83%) met all the standards. • The availability of appointments within standards for new members changed from fifty-four percent (54%) to seventy-eight percent (78%) from the audits that were conducted last quarter. Following the audit, providers received notification of results in writing which also outlined the standards. Those who did not meet the appointment timeliness standard receive a follow up audit in ninety (90) days. If adherence to the standards does not improve, providers are subject to a corrective action plan.

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Table 10-Behavioral Health Appointment Timeliness Standards

Describe the method(s) used by the MCE to monitor its contract's timeliness requirements for members' access to behavioral health services. Describe findings specific to the current reporting period.
CHP+ MCO, RAE
Behavioral health providers are expected to maintain access to appointments with standards established by the State of Colorado. The standards indicate providers should have appointment availability for members within seven (7) days of request, and that urgent access is available within twenty-four (24) hours from the initial identification of need. Audits conducted between January 2021 through March 2021 across 19 behavioral health providers assessed appointment availability for new Medicaid members and existing Medicaid members. Results from the audits were as follows: • Twenty-two percent (22%) reported availability within standard for a new Medicaid member. • Twenty-two percent (22%) reported availability within standards for an established Medicaid member. • Twenty-two percent (22%) met all the standards. The availability of appointments within standards for new members reduced from thirty-five percent (35%) from the audit last quarter to twenty-two percent (22%). A reduction of thirteen percent (13%). The reduction of thirteen percent (13%) is reportedly attributed to reduced capacity and full caseloads. NHP is outreaching and reviewing with provider's expectations of availability of appointments and the expectations for the providers audited this quarter. We have been trying to be conscientious in this outreach as, unfortunately, some of the full caseloads are due to limited space and face-to-face capacity within offices and the comfortability and willingness for members to attend appointments with individuals based on who is or is not vaccinated. Following the audit, providers received notification of results in writing which also outlined the standards. Those who did not meet the appointment timeliness standards receive a follow up audit in ninety (90) days. If adherence to the standards does not improve, providers are subject to a corrective action plan. However, a corrective action plan is extreme and we would not want providers to be on a CAP and further stress their resources. Rather we want a process where they help ensure a member is linked to care or our call center to assist in accessing care versus a denial of access to services. Providers are outreached and offered supports, education on standards, and the opportunity to have another audit completed to improve scores and avoid corrective action plans whenever possible.

Health Care Network Time and Distance Standards

Supporting contract reference: The MCE shall ensure that its network has a sufficient number of practitioners, practice sites, and entities who generate billable services within their zip code or within the maximum distance for their county classification. The MCE must use GeoAccess or a comparable service to measure the travel time and driving distance between where members live and the physical location of the practitioners/practice sites/entities in the MCE's Region.

Enter time and distance compliance results (e.g., "Met" or "Not Met") in the MS Excel template. Use Tables 11, 12, and 13 for additional relevant information regarding the MCE's compliance with time and distance requirements. Geographic regions refer to the areas in which members reside, as members may travel outside their county of residence for care. For physical health time and distance requirements, MCEs are only required to report data for members residing inside the MCE's contracted counties. For statewide behavioral health time and distance requirements, MCEs are required to report results for all members regardless of county residence.

- CHP+ MCO defines "child members" as 0 through the month in which the member turns 19 years of age.
- CHP+ MCO defines "adult members" as those over 19 years of age (beginning the month after the member turned 19 years of age).
- Medicaid MCO and RAE define "child members" as under 21 years of age.
- Medicaid MCOs and RAEs define "adult members" as those 21 years of age or over.

There are two levels of primary care practitioners: primary practitioners that can bill as individuals (e.g., MDs, DOs, NPs, and CNS') and mid-level practitioners that cannot bill as individuals (e.g., PAs); each type of practitioner has its own row in the MS Excel template tabs for time/distance reporting.

A practitioner/practice site/entity should only be counted one time in the MCE's data submission; if a practitioner provides primary care for the Adult-Only or Pediatric network categories (and is not an Obstetrician/Gynecologist), the MCE should count the primary care practitioner one time under the Family Practitioner network category.

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Table 11–Urban Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's urban counties using the accompanying MS Excel workbook template. **List the specific urban counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in urban Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
NHP has one (1) urban county, Weld, which is where to the majority of NHPs' members reside or are attributed. The requirement for an urban county is to have one hundred percent (100%) coverage of two (2) providers within thirty (30) miles or thirty (30) minutes. Behavioral Health Within Weld County, NHP did not have one hundred percent (100%) coverage of members within the time/distance requirement for any Network Categories. NHP conducted a GeoAccess analysis that observed a ninety-five percent (95%) overall coverage for its entire membership. Weld County had a ninety-nine and half percent (99.5%) coverage of provider to members for the following behavioral health provider types: • General Psychiatrists and Other Psychiatric Prescribers • General Behavioral Health • General SUD Treatment Practitioner • Pediatric Psychiatrists and Other Psychiatric Prescribers • Pediatric Behavioral Health • Pediatric SUD Treatment Practitioner Urban counties outside of NHP (Arapahoe, Clear Creek, El Paso and Elbert counties) had less than ninety-five percent (95%) coverage for Adult Psychiatric and other Psychiatric Prescribers, Adult Substance Abuse Disorder Provider, Pediatric Psychiatric and other Psychiatric Prescribers, Pediatric Mental Health Provider, and/or Pediatric Substance Abuse Disorder Provider. Should members in these counties need additional provider options beyond the network, NHP considers Single Case Agreements (SCAs) when appropriate. Weld County had significant access to Psychiatric Units in Acute Care Facilities with eighty-six percent (86%) coverage. Other Urban counties had limited access, including Adams, Arapahoe, Boulder, Clear Creek, Douglas, El Paso, Gilpin, Pueblo, and Teller. In most counties at least one Psychiatric Units in Acute Care Facilities is within the time and distance; however, there was no option for two (2) facilities in every Urban county as required by the standards. *SUD Benefit* Effective January 1, 2021, NHP provides the full continuum of Substance Use Disorder (SUD) benefits for Medicaid members. NHP is recruiting all available facilities serving NHP members to participate in its network. Based on the specifications of this quarterly report, NHP had limited coverage for members in Weld County by service level as follows: • Ninety-two percent (92%) coverage for Clinically Managed Low-Intensity Residential Services (ASAM level 3.1) and Clinically Managed High-Intensity Residential Services (ASAM level 3.5)

- Ninety-one percent (91%) for Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM)
- Forty-two percent (42%) coverage for Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM)
- NHP had zero percent (0%) coverage for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3) and Medically Monitored Intensive Inpatient Services (ASAM level 3.7) due to lack of providers that have the license level within the standard time and distance.

Physical Health

NHP did not have one hundred percent (100%) coverage for members within the time/distance requirement for any Network Categories. Weld had a ninety-nine percent (99%) coverage of provider to members for the following categories:

- Adult Primary Care (MD, DO, NP)
- Adult Primary Care (PA)
- Pediatric Primary Care (MD, DO, NP)
- Pediatric Primary Care (PA)
- Family Practitioner (MD, DO, NP)
- Family Practitioner (PA)
- Gynecology, OB/GYN (MD, DO, NP)

NHP had eighty-nine percent (89%) coverage for Gynecology, OB/GYN (PA). Both Adult Primary Care (MD, DO, NP) and Adult Primary Care Mid-Level provider types improved from the previous quarter of less than fifty percent (50%) coverage. The improvements are related to the template changes to these Provider Types as there was no changes in the network from previous quarter.

Table 12–Rural Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's rural counties using the accompanying MS Excel workbook template. **List the specific rural counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in rural Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
Logan, Morgan, and Phillips Counties are qualified as rural counties. The majority of the members had access to two (2) providers within the required distance of forty-five (45) minutes or forty-five (45) miles for PCPs, and sixty (60) minutes or sixty (60) miles for behavioral health providers. Behavioral Health All of the rural counties within the NHP region met the standards for an adequate network. General SUD Treatment Practitioners and Pediatric SUD Treatment Practitioners had nearly one hundred percent (99.9%) coverage and noted as not met access per the guidelines of the file *GeoAccess Compliance*. The slight decline

in access for the SUD Treatment Practitioners may be related to the template changes to these Provider Types. NHP had zero percent (0%) coverage for Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. In most counties one of these facilities is within the time and distance; however, there was no option for two (2) facilities in NHPs' rural counties as required by the standards.

For rural counties outside NHP, most met the standards except for Delta, Eagle, Garfield, Montrose, and Routt for Substance Abuse Disorder Providers for adults and pediatrics. If a member needs services with providers outside of those available in the area, then NHP connects the member with the closest available provider and assists the member with transportation if necessary.

Psychiatric Units in Acute Care Facilities within standard distance and ratio are limited for all rural counties with NHP members. In most counties one of these facilities is within the time and distance; however, there was no option for two (2) facilities in rural counties as required by the standards.

SUD Benefit

NHP is contracting with all available facilities to participate in its network. Based on the specifications of this quarterly report, NHP had limited coverage for members in rural counties by service level. Morgan County had limited access with the standards as follows: Seventy percent (70%) Clinically Managed Low-Intensity Residential Services (ASAM level 3.1), Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM), and Clinically Managed High-Intensity Residential Services (ASAM level 3.5); however, Logan and Phillips had no coverage across all levels of services within the standard time and distance requirements. NHP had zero percent (0%) coverage across its three (3) rural counties due to lack of providers that have the license level within the standard time and distance for Clinically Managed Population-Specific High-Intensity Residential Services (ASAM level 3.3), Medically Monitored Intensive Inpatient Services (ASAM level 3.7) and Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM).

<u>Physical Health</u>

For Physical Health, NHP had full coverage across all three (3) rural counties for the following categories:

- Adult Primary Care (MD, DO, NP)
- Pediatric Primary Care (MD, DO, NP)
- Family Practitioner (MD, DO, NP)

In addition, NHP met one hundred percent (100%) coverage of members within the time/distance and ratios requirements for Adult Primary Care (PA), Pediatric Primary Care (PA), Family Practitioner (PA), and Gynecology, and OB/GYN (MD, DO, NP) in Morgan County.

NHP conducted a GeoAccess analysis of coverage, which showed almost one hundred percent (99.8%) coverage in Logan County for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). Further, Phillips County had a ninety-five percent (95%) coverage for those same Provider Types. This improvement is related to the template changes to these Provider Types for this quarterly report as there were no changes in the network from previous quarter.

The rural counties had zero percent (0%) coverage for Gynecology, OB/GYN (MD, DO, NP) and Gynecology, OB/GYN (PA). Rural counties lack practitioners with specialties such as Primary Care Providers that offer Gynecology services within the time/distance standard for contracting.

Table 13–Frontier Health Care Network Time and Distance Standards: Discussion

Present detailed time/distance results for members residing in Colorado's frontier counties using the accompanying MS Excel workbook template. **List the specific frontier counties in which the MCE does not meet the time/distance requirements. Describe the MCE's approach to ensuring access to care for members residing in frontier Colorado counties where the MCE does not meet the time/distance requirements.**
CHP+ MCO, Medicaid MCO, RAE
The majority of the counties within Region 2 qualify as frontier including Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma. Most of the members within these counties had access to two (2) providers within the required distance for all provider types within the required distance of sixty (60) minutes or sixty (60) miles for PCPs, and ninety (90) minutes or ninety (90) miles for behavioral health. Behavioral Health The six (6) frontier counties met the time/distance and ratios requirement for all the Network Categories with the exception of Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. Similarly, the majority of the frontier counties outside Region 2 with NHP members met the access requirements for all Network Categories with the exception of Psychiatric Hospitals or Psychiatric Units in Acute Care Facilities. If a member needs services with providers outside of those available in the area, then NHP, connects the member with the closest available provider and assists the member with transportation if necessary. *SUD Benefit* Although NHP is contracting with all available facilities in the surrounding counties of the frontier region, there are no licensed providers, for every level of care, located within the frontier counties. As a result, members in frontier counties had no access to providers within the time and distance standards. The exception was Lincoln County with eighty-six percent (86%) coverage to Clinically Managed Residential Withdrawal Management (ASAM level 3.2WM), sixty-seven percent (67%) coverage for Medically Monitored Intensive Inpatient Services (ASAM level 3.7), and sixty-three percent (63%) coverage for Medically Monitored Inpatient Withdrawal Management (ASAM level 3.7WM). Physical Health For Physical Health, NHP had full coverage across its frontier counties for the following categories: • Adult Primary Care (MD, DO, NP) • Pediatric Primary Care (MD, DO, NP) • Family Practitioner (MD, DO, NP)

For Lincoln, Washington and Yuma counties NHP met one hundred percent (100%) coverage of members within the time/distance and ratios requirements for the Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA) categories.

NHP conducted a GeoAccess analysis of coverage, which showed almost one hundred percent (99.8%) coverage in Kit Carson County for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). The improvements are related to the template changes to these Provider Types for this quarterly report as there were no changes in the network from previous quarter. Further, Washington County had a ninety percent (90%) coverage for Gynecology, OB/GYN (MD, DO, NP).

Cheyenne and Sedgwick had less than fifty percent (50%) coverage for Adult Primary Care (PA), Pediatric Primary Care (PA), and Family Practitioner (PA). The following counties had zero percent (0%) coverage for Gynecology, OB/GYN (MD, DO, NP) and Gynecology, OB/GYN (PA): Cheyenne, Kit Carson, Lincoln, Sedgwick, Washington, and Yuma. Frontier counties lack practitioners with specialties such as Primary Care Providers that offer Gynecology services within the time/distance standard for contracting.

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Appendix A. Single Case Agreements (SCAs)

Individual practitioners with single case agreements (SCAs) are not counted as part of the MCE's health care network and should be excluded from tabulations in the body of this MS Word report and the associated MS Excel report(s). However, the Department acknowledges the role of SCAs in mitigating potential network deficiencies and requests that the MCE use Tables A-1 and A-2 below to list individual practitioners or SUD treatment facilities with SCAs and describe the MCE's use of SCAs.

Table A-1-Practitioners and SUD Treatment Facilities with SCAs: Data

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
Franklin Q. Smith	*0000000*	*Denver*	*PV050*	*Adult Only Primary Care*	
Chrysalis Behavioral Health	*0000000*	*Baca*	*BF085*	*SUD Treatment Facility, ASAM Levels 3.1 and 3.3*	
CHP+ MCO, Medicaid MCO, RAE					
BAGWELL, STEPHANIE	9000149084	Larimer	BV080	Licensed Addiction Counselors (LACs)	
BARCELO, DANIELLE	9000183792	Weld	BV131	Licensed Marriage & Family Therapists (LMFTs)	
BARRON-KRIER, NATAEAH	9000151724	Larimer	BV131	Licensed Marriage & Family Therapists (LMFTs)	
BINDSEIL, RICHARD	64238334	Boulder	BV100	Psychiatrists	
BRANDT, FAITH	00135038	Larimer	BV132	Licensed Professional Counselors (LPCs)	
COFFMAN, ERIN	9000172261	Weld	BV132	Licensed Professional Counselors (LPCs)	
CONNER, ABBIE	24320056	Larimer	BV080	Licensed Addiction Counselors (LACs)	
ENGLISH, RAYMELL	9000181651	Boulder	BV132	Licensed Professional Counselors (LPCs)	
FESTA, NICOLE	9000166266	Adams	BV080	Licensed Addiction Counselors (LACs)	
FITZGERALD, MORNING	9000168307	Boulder	BV131	Licensed Marriage & Family Therapists (LMFTs)	

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
FROST, HELEN	38812541	Weld	BV080	Licensed Addiction Counselors (LACs)	
GERARDO, SANDRA	9000188222	Boulder	BV130	Licensed Clinical Social Workers (LCSWs)	
GONZALES, MELISSA	9000177903	Larimer	BV132	Licensed Professional Counselors (LPCs)	
HARGETT, HARL	07015662	Jefferson	BV080	Licensed Addiction Counselors (LACs)	
HIGHT, JODIE	9000154372	Larimer	BV130	Licensed Clinical Social Workers (LCSWs)	
JOHNSON, ADAM	9000183633	Larimer	BV132	Licensed Professional Counselors (LPCs)	
LUTZ, JAMES	42120250	Weld	BV132	Licensed Professional Counselors (LPCs)	
MATRA, DANIELLE	9000155124	Larimer	BV130	Licensed Clinical Social Workers (LCSWs)	
MORTENSEN, D KILEY	90002075	Boulder	BV100	Psychiatrists	
RICHTER, EMILY	9000142905	Larimer	BV120	Psychologists (PhD, PsyD) - General	
SHULL, AMY	9000162931	Larimer	BV131	Licensed Marriage & Family Therapists (LMFTs)	
WHITNEY, SHAWN	9000151986	Larimer	BV080	Licensed Addiction Counselors (LACs)	
WILLEY, BREANNE	9000182531	El Paso	BV132	Licensed Professional Counselors (LPCs)	
COLORADO WEST REGIONAL MENTAL HEALT	9000187517	Mesa	BF085	ASAM Level 3.2 WM	
CROSSROADS TURNING POINTS INC	9000187246	Pueblo	BF085	ASAM Level 3.2 WM	
CROSSROADS TURNING POINTS INC	9000187246	Pueblo	BF085	ASAM Level 3.5	
DENVER SPRINGS LLC	9000152845	Arapahoe	BF085	ASAM Level 3.7 WM	

SCA Practitioners or SUD Treatment Facilities	Medicaid ID	County Name	HCPF Network Category Code(s)	HCPF Network Category Description (include ASAM levels for SUD treatment facilities)	Number of Members Served by SCA
MILE HIGH BEHAVIORAL HEALTHCARE	9000165918	Denver	BF085	ASAM Level 3.5	[redacted]
NORTH RANGE BEHAVIORAL HEALTH	9000164589	Weld	BF085	ASAM Level 3.5	
NORTH RANGE BEHAVIORAL HEALTH (ATU)	04190096	Weld	BF085	ASAM Level 3.2 WM	
POUDRE VALLEY HEALTH CARE INC	9000169084	Larimer	BF085	ASAM Level 3.7 WM	
POUDRE VALLEY HEALTHCARE INC	9000169084	Larimer	BF085	ASAM Level 3.7 WM	

Table A-2-Practitioners with SCAs: Discussion

Describe the MCE's approach to expanding access to care for members with the use of SCAs. Describe the methods used to upgrade practitioners with SCAs to fully contracted network practitioners.
CHP+ MCO, Medicaid MCO, RAE
Out-of-network providers can request Single Care Agreements (SCAs) to render services for NHP members for the purpose of continuity of care or specialty services that are not available through the current network. The following comments apply to the 23 individual providers who received SCAs during the reporting period: ➢ Three (3) providers were part of an inpatient episode where choice of network providers may be limited due to hospital privileges. ➢ Two (2) completed their credentialing during the reporting period. ➢ Ten (10) were part of contracted groups and are undergoing credentialing. Lifestance (formerly Heart Centered Counseling) and KidStuff Child and Family Counseling are large groups within the network, have a strong relationship with NHP, and receive a high volume of referrals. While their providers complete credentialing, the groups use SCAs for their providers to start working with NHP members. These providers account for a large number of members under SCAs in this report. Specifically, both James Lutz with 43 members and Danielle Matra with [redacted] members are part of Lifestance and are pending credentialing. Providers in the credentialing process and who are using SCAs to render services are monitored to ensure they complete credentialing and formally join the network. ➢ Eight (8) providers were being monitored for number of SCAs to identify if they are appropriate for recruitment. NHP monitors SCA data on a monthly basis to recruit those providers that have received multiple SCAs and are not in the credentialing process. As the first quarter of the new SUD benefit, NHP used SCAs to help ensure access to the new benefit. Providers negotiating their contracts were able to request SCAs to serve on-going or new members.

Contracted providers pending credentialing did not require SCAs. The process improved transitions of care, increased provider satisfaction, and reduced administrative burden. NHP monitors SCAs for the new SUD benefit to identify potential providers for recruitment.

Appendix B. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.

Instructions for Appendices

To add an image:

- Go to "Insert" and click on "Pictures".
- Select jpg file and click "Insert".

To add an additional Appendix:

- Go to "Layout" and click on "Breaks".
- Select "Next Page" and a new page will be created.
- Go to "Home" and select "HSAG Heading 6".
- Type "Appendix C." and a descriptive title for the appendix.
- Select the Table of Contents and hit F9 to refresh.

Optional MCE Content

Free text

Appendix C. Optional MCE Content

This optional appendix may contain additional information, graphs, or maps that the MCE would like to include in its quarterly report.